

Leonard I. Nunnally, III, DDS, PC

11531 Nuckols Road Suite B

Glen Allen, VA 23059

MISSED APPOINTMENTS

We require at least 24 hours notice if you must cancel an appointment, failure to do so may result in a broken appointment charge of \$25.00 per half hour of your missed appointment. Once an appointment has been made, please remember this time has been reserved specifically for you.

SERVICE CHARGES

Be advised our office policy is to charge monthly interest of 1.5% (18% Annual Percentage Rate). This will be applied to all accounts over 90 days, regardless of the insurance involvement. There will be a \$25.00 handling fee for any returned check.

INSURANCE ASSIGNMENTS

Our office participates with or is able to accept many (but not all) insurance company assignments. Patients are required to pay their estimated copay at the time of service. Estimates provided by this office are considered a guideline and are not a guarantee of payment. Our office will submit the patient's claim promptly after treatment. Any balance not covered by the patient's insurance company is the patient's responsibility.

COLLECTION FEE

The office does pursue legal action when an account is delinquent. Should this account become delinquent, the patient (or parent/guardian if patient is a minor) agrees to pay all collection and court costs, including attorney fees in the amount of 1/3 (one third) of the unpaid balance.

NOTICE OF PATIENT PRIVACY

A copy of the Health Insurance Portability and Accountability Act (HIPAA) is available upon request.

FINANCIAL CONSENT

I agree to be fully responsible for total payment of procedures performed in this office, including any treatment rendered that is not covered by my dental insurance(s). I certify that I have read, understand, and agree to this. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I authorize the release of all pertinent dental information to any insurance company that is necessary to process my claims. I request payment of benefits to be made to Leonard I. Nunnally III, DDS a division of Central Virginia Dental Care. I authorize the use of my signature on all insurance submissions.

Print Patient's Name: _____

Signature _____ Date _____

(Patient, Parent or Guardian sign above)